Filed for intro on 01/20/2000

SENATE BILL 2925
By Blackburn

AN ACT to enact the Millennial TennCare Health Coverage Reform and Renewal Act and to amend Tennessee Code Annotated, Title 29; Title 56 and Title 71.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. The general assembly finds that hospitals and physicians who treat persons involved in accidents bear a disproportionate share of the risk of non- or substantially reduced payment arising from treating accident patients and that tortfeasors, casualty insurers or others rely on reimbursing the substantial discount health care providers have contractually entered into with health care payors, including TennCare participants, and that such results in an unjust enrichment to tortfeasors, casualty insurers and others. Therefore, Tennessee Code Annotated, Title 29, Chapter 22, is amended as follows:

(a) The word “Hospital” in the title shall be substituted with “Health Care Provider” to read “Health Care Provider Liens;”

(b) A new section 29-22-101 shall be added, redesignating all subsequent sections accordingly, which shall state:

Section 29-22-101. Health Care Provider Defined.

For purposes of this chapter “Health Care Provider” shall only mean a person licensed to practice medicine pursuant to Part 2 of Chapter 6 to Title 63, and a hospital as defined pursuant to Title 68, Chapter 11, Part 2.

(c) In redesignated Section 29-22-102:

(1) Delete sub-part (a) in its entirety substituting the following:

(a) Every health care provider in this state shall have a lien for all reasonable and necessary charges for care, treatment and maintenance of ill or injured persons upon any and all causes of action, suits, claims, counterclaims or demands accruing to the person to whom such care, treatment or maintenance was furnished, or accruing to the legal representatives of such person in the case of his or her death, on account of illness or injuries giving rise to such causes of action or claims and which necessitated such care, treatment and maintenance.

(2) Delete sub-part (b) and replace it with existing sub-part (c):

(3) Add as a new sub-part (c) the following:

(c) Health care providers are authorized to file liens pursuant to this part up to and including their complete billed charge for reasonable and necessary medical care, treatment and maintenance, provided, however, that within thirty (30) days of receipt of payment that satisfies a lien, the health care provider shall execute and file necessary release(s) of said lien, and shall refund, net incurred filing costs and certified mail expenses, to any person who made payment the lesser of:

(1) The sum received in satisfaction of the lien; or

(2) The amount of the prior payment.

(4) Add as a new sub-part (d) the following:

(d) If a health care provider contracts with an independent, unrelated person, company or otherwise, to administer lien rights set forth in this part, the health care provider may also include the costs of administration as an incurred filing cost, provided the total amount of

administration does not exceed fifteen percent (15%) of aggregate lien receipts.

(5) Add as a new sub-part (e) the following:

(e) Liens authorized and filed pursuant to this part earlier in time shall have priority over later filed liens, without regard as to amount.

(d) The provisions of redesignated Section 29-22-102 shall be deleted in their entirety and replaced with the following:

Section 29-22-102. Perfection of Lien; Verified Statement; Notice; Contest.

(a) In order to perfect such lien, the health care provider, or its designee, before or within one hundred twenty (120) days after any such person shall have been discharged or completed treatment therefrom, shall file in the office of the clerk of the circuit court of the county in which the health care provider is located a verified statement in writing setting forth the name and address of the patient as it appears on the records of the health care provider, its address, the treatment dates and/or the dates of admission and discharge of the patient therefrom, the amount claimed to be due for such care, and to the best of the claimant's knowledge, the names and addresses of persons, firms or corporations claimed by such ill or injured person or by such person's legal representative, to be liable for damages arising from such illness or injuries.

(b) A copy of the verified statement shall, within ten (10) days from the filing thereof, be sent by registered mail, postage prepaid, to each person, firm or corporation so claimed to be liable on account of such illness or injuries, at the address given in the statement, and to person to whom services were rendered by the health care provider.

(c) The filing of the verified statement shall be notice thereof to all persons, firms, or corporations who may be liable on account of such illness or injuries, whether or not they are named in the claim or lien and whether or not a copy of the claim shall have been received by them.

(d) Any person desiring to contest such a lien or the reasonableness of the charges thereof may do so by filing a motion to quash or reduce the same in the circuit court of the county in which the lien was perfected, making all other parties in interest respondents thereto. Any such motion may be heard in term time or vacation and at such time and place as may be fixed by order of the court. Payment by another, whether or not the health care provider reserved the right to bill a patient for the balance, is no defense to enforcement or grounds for the quashing or invalidation of a properly perfected health care provider lien.

(e)(1) If at the time an insurance carrier or other person, corporation or entity reaches a settlement and obtains a release of liability on or pays a claim filed by a policyholder or other person against such carrier, person, corporation or other entity, the health care provider providing treatment to such policyholder or person has not perfect a lien as set out in the section, any lien perfected subsequent to such settlement or payment shall not apply to or create any additional liability on the part of the insurance carrier or other person, corporation or entity paying the settlement or claim.

(2) The provisions of this subsection shall not apply until thirty (30) days after any such person is served by a health care professional or discharged from a hospital.

(e) Redesignated Section 29-22-104 shall be amended by replacing all indications of the word “hospital” or “Hospital” with “Health Care Provider”.

(f) Add to the end of redesignated Section 29-22-105(a): “as well as a reasonable attorney’s fee for having to enforce the lien.”

(g) Replace “the operator of the hospital” and “hospital” with “Health Care Provider” in all instances of redesignated Section 29-22-106.

(h) Redesignated Section 29-22-107 shall be deleted in its entirety and replaced with the following:

Section 29-22-107. Payment to Health Care Provider.

Payment in satisfaction of a lien authorized by this part shall be made payable only the health care provider or its designee and in no case shall a patient and the health care provider be named as co-payees on any draft.

SECTION 2. The general assembly finds that current law does not adequately address the previously stated legislative goal that in all cases the TennCare program be the payor of last resort, that equitable notions such as an injured TennCare recipient being made whole from a third party has no application to the reimbursement of TennCare benefits and that allowing such is tantamount to permitting the third party to escape the full measure of liability for its actions. Therefore, Title 71, Chapters 1 and 5 of the Tennessee Code Annotated, are amended as follows:

(a) By deleting subsections (a) through (c) of Section 71-1-123, and Section 71-5-117, redesignating any remaining subsections and replacing that deleted with:

(a) Statements of Intent and Construction.

(1) This title provides essential medical care and rehabilitative services for eligible persons under this code and it is the purpose of this part to balance the cost of medical care when such occurs through the fault of a third party, or for which a third party maybe liable, between that of the third party, the recipient and TennCare; and

(2) It is the intent of the Tennessee general assembly that TennCare, and any TennCare HMO, be the payer of last resort for medical expenses on behalf of recipients, and resolution of any issue(s) regarding medical claim payment, recovery, reimbursement, avoidance, or otherwise, shall be such that minimizes to the maximum extent possible expenditures of TennCare and/or the participating TennCare HMOs; and

(3) The general assembly hereby expressly abrogates any common-law or other doctrine, whether consistent or inconsistent with this part.

(b) Definitions. As used herein, the following terms shall be defined as

(1) "Cost of Care" means the actual amounts paid or payable in the future by TennCare, as defined herein, as payment for the diagnosis, care, treatment and maintenance of a recipient, as defined herein; provided, however, if healthcare providers are paid a monthly capitated fee, or a fixed amount per month regardless of the need or use of medical services, then, in only such cases, "cost of care" shall mean the healthcare provider's reasonable and customary charge for such items or service in the absence of capitation arrangements;

(2) "Insurance Benefits" means payments or payables for the benefit of a recipient arising from:

(A) sickness, injury, disease, disability, or death, due to the liability of a third party; or

(B) casualty insurance secured by the recipient that purports to compensate a recipient upon the happening of an event causing the recipient injury, including but not limited to:

casualty, liability, medical payments, no-fault, personal injury protection or uninsured or underinsured motorist coverage, coverage to the recipient or members of the recipient's household by virtue of a homeowner's, renter's or other personal casualty protection;

(3) A "party to a claim" includes the recipient or the recipient's legal representative, the injured person or the person's legal representative, the plaintiff, the defendants, or persons alleged to be responsible for compensating the injured person or plaintiff, including but not limited to, casualty insurers whether insuring the plaintiff, recipient or defendant(s), and any other party to the cause of action or claim;

(4) "Recipient" means the individual accepting assistance under this title and the parents, legal representatives of other legal guardians of the individual accepting assistance;

(5) "Recovery" means any item of value, whether in cash or in kind, and without regard to character or characterization as to any particular item or sub-item of damages, received by, or promised to be delivered to a recipient as:

(A) compensation for injury, disease, disability, or death of a recipient; and/or

(B) the giving by a recipient of a covenant not to sue, a release, or any other forbearance of recipient to assert claims of compensation against a third party;

(6) "TennCare" means the state of Tennessee, the Department of Health, the Department of Commerce & Insurance, the Department of Finance & Administration, and any HMO in good standing and under

contract with the state to finance, provide and/or to arrange for the medical care of a recipient under this chapter; and

(7) "Third Party" means any person, corporation, group, plan, insurer or otherwise, other than the recipient or TennCare, that may be liable to a recipient:

(A) in tort;

(B) by virtue of a contractual relationship with the recipient; or

(c) another relationship imputed by law with the recipient;

(c) State's First Priority Lien. The state shall have a first priority lien for the cost of care provided a recipient of assistance under this title upon any moneys or other property accruing to the recipient or the recipient's legal representatives, as a result of sickness, injury, disease, disability, or death, due to the liability of a third party which necessitated the medical care, or for which any third party may be liable or for which other benefits or compensation may be owing by any means, including but not limited to any type of automobile liability, no-fault, medical payments, personal injury protection or other type of insurance;

(1) In order to perfect and enforce any lien arising under this title by TennCare must comply with the procedures set forth for hospital liens in Title 29, Chapter 22 of the Tennessee Code Annotated; except:

(A) TennCare shall have one (1) year from the date the last item of medical care was furnished to file its verified lien statement; and

(B) The statement shall be filed with the appropriate clerk of the circuit court in the county wherein the recipient resides and with the circuit court clerk for Davidson County.

(d) Assignment by Recipient. A recipient of medical assistance who receives medical care for which the state or a participating TennCare HMO may be obligated to pay shall be deemed to have made assignment to the state and the applicable TennCare HMO of any rights of such person to any payments for such medical care from a third party, up to the amount of medical assistance actually paid by the department; provided, however, assignment does not attach to a recipient's right to any payments provided under private health care coverage prior to the receipt of written notice, by the carrier who issued the health care coverage, of the exercise by the department of its assignment. This subsection shall apply to a recipient only if notice of this subsection is given to the recipient at the time his application for medical assistance is filed. The assignment created by this subsection shall be effective until the recipient of medical assistance is no longer an eligible recipient for medical assistance.

(e) Notice Requirements. TennCare must be given notice of monetary claims against any person, firm, or corporation that may be liable to pay part or all of the cost of medical care when TennCare has paid or may be liable for the cost of care. Notice must be given as follows:

(1) Recipients shall notify TennCare or its designee of any possible claims when they submit the application. Recipients of medical assistance shall notify their TennCare HMO of any possible claims when those claims arise subsequent to the application.

(2) Healthcare providers providing medical care services to a recipient shall notify the TennCare HMO within twenty-four (24) hours of treating the recipient when the provider has reason to believe another party may be liable for payment of the cost of medical care.

(3) A party to a claim upon which the state or a TennCare HMO may be entitled to a lien under this section shall notify the TennCare HMO or its designee of the potential lien claim at each of the following stages of a claim:

(A) when a claim is filed;

(B) when an action is commenced; and

(C) when a claim is concluded by payment, award, judgment, settlement, or otherwise.

(4) If the notice required under this part is not provided, all parties to the claim are deemed to have failed to provide the required notice. Parties to a claim shall be jointly and severally liable to TennCare for the cost of care, as well as attorney's fees and expenses, upon consummation of a claim absent the required notice, or disbursement of monies in derogation of TennCare's first priority lien.

(f) Comparative Fault. The comparative fault or contributory negligence of the recipient shall not be imputed to TennCare.

(g) Disbursements Subject to Lien. Upon any judgment, award, or settlement of a cause of action, claim, or otherwise, or any part of it, upon which the state or the TennCare HMO has filed and perfected a lien pursuant to this part, including compensation for liquidated, unliquidated, or other damages, shall be disbursed as follows until exhausted:

(1) A reasonable attorney fee and reasonable, both in scope and amount, litigation expenses, incurred securing the claim, settlement, judgment or otherwise;

(2) The full amount of medical assistance paid by TennCare on behalf of the recipient as a result of the injury. TennCare's lien may not

be reduced to reflect an assessment of a pro rata share of the recipient's attorney's fees or litigation costs;

(3) The remainder shall be paid to the recipient or other plaintiff.

SECTION 3. The general assembly finds that medical care is financed by the TennCare MCOs for many persons that are victims of crime, that present law does not provide an adequate means of funding this care and that in compensating for these injuries TennCare MCOs are similarly impacted and should be entitled to claim compensation to the extent payment is made or available on behalf of a crime victim. Therefore, Title 29, Chapter 13, of Tennessee Code Annotated is amended as follows:

(a) By inserting the following as subdivision (11) and redesignating Tennessee Code Annotated, Section 29-13-102, accordingly:

(11) *"TennCare HMO"* means a health maintenance organization or other managed care organization in good standing and under contract with an authorized by the Bureau of TennCare to provide medical care, treatment and maintenance to enrollees in that program;

(b) By adding a new subsection (c) to Tennessee Code Annotated, Section 29-13-103, as follows:

(c) If the claimant is a TennCare HMO it must present written documentation to establish all the facts required by subsection (a), except subdivisions (4) and (7). Such documentation shall include, where appropriate, a summary of medical claims submitted and paid by the TennCare HMO indicating the claim number, date of service, ICD-9 and CPT-4 codes, health care provider, billed charge and paid amount, or if unpaid, an indication of the reason therefore with an accompanying legend describing such indicators.

(c) By adding a new subdivision (6) to Tennessee Code Annotated Section 29-13-105(a) as follows:

(6) In the case of personal injury of death of the victim, where the victim was enrolled in the state medical assistance program known as TennCare, where medical expenses for the care, treatment and maintenance of the victim were paid, in whole or in part, by a TennCare HMO, and said expenses arose from a criminal act, then to that TennCare HMO;

(d) Except for claims brought by a TennCare HMO:

(1) Any award shall be reduced by the amounts of payment already received or any amounts which claimant is legally entitled to receive as a result of the injury;

(A) From or on behalf of the offender;

(B) From any other public or private source; or

(C) As an emergency award pursuant to § 29-13-114.

(2) It is the intent of this subsection to prohibit double recoveries by criminal victims, but it shall not be construed to prohibit recovery of compensation under this chapter if the recovery from the sources set forth in subdivisions (f)(1)(A) and (B) is insufficient to reimburse the victim for total compensable injuries as set forth in this chapter. Recoveries under subdivisions (f)(1)(A) and (B) shall be considered as primary indemnification, and recoveries under subsection (a) shall be limited to compensating for injuries over and above any recoveries under subdivisions (f)(1)(A) and (B). In claims involving the death of a victim, the proceeds from any life insurance contracts payable to the victim's dependent(s) making the claim for compensation shall not be considered a source of reimbursement.

(f) Adding new subsection (d) to Tennessee Code Annotated Section, 29-13-112, as follows:

(d) No attorney fee may be awarded to an attorney representing a TennCare HMO seeking compensation under this chapter.

SECTION 4. All provisions of this Act, except Section 2, shall take effect upon becoming law, the public welfare requiring it. Section 2 of this Act shall take effect July 1, 2000, the public welfare requiring it.